



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.maine.gov/bhr/oe>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-844-273-4614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$600/individual or \$1,200/family for <a href="#">network providers</a> . \$3,000/individual or \$6,000/family for <a href="#">out-of-network providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the calendar year <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and vision exam for <a href="#">network providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the calendar year <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet a separate <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$2,000/individual or \$4,000/family; for <a href="#">out-of-network providers</a> \$5,000/individual or \$10,000/family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a calendar year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Prescription drugs</a> , <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-844-273-4614 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . Note, some specialists may require a referral regardless of <a href="#">plan</a> rules.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /office visit	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /office visit	40% <a href="#">coinsurance</a>	<p><a href="#">Specialist network</a> office visit <a href="#">copay</a> for mental health, behavioral health and substance abuse services \$20. (See page 3.)</p> <p>Spinal manipulation office visits limited to 25 visits per calendar year.</p> <p><a href="#">Referrals</a> not required.</p>
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	<p>Routine eye exam limited to one per calendar year.</p> <p>Mammograms: No charge for <a href="#">screening, medically necessary</a>, 2D &amp; 3D. No charge for <a href="#">out-of-network providers</a>.</p> <p>Colonoscopy (<a href="#">screening &amp; medically necessary</a>): No charge for prep age 40 and over.</p> <p>Nutritional counseling; unlimited visits &amp; no diagnosis required.</p> <p>Tobacco cessation counseling visits unlimited.</p> <p>Hepatitis C Virus (HCV) test for people at high risk for infection and a one-time <a href="#">screening</a> for adults born between 1945 and 1965.</p> <p>You may have to pay for services that aren't <a href="#">preventive</a>. Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a>. Then check what your <a href="#">plan</a> will pay for.</p>

For more information about limitations and exceptions, see plan or policy document at [www.maine.gov/bhr/oe/](http://www.maine.gov/bhr/oe/).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (lab work & imaging)	For independent facilities no charge; all other <a href="#">network providers</a> 10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	See above for <a href="#">preventive screening</a> coverage.  Not all <a href="#">providers</a> perform the same services. To find a <a href="#">provider</a> <a href="http://www.anthem.com">www.anthem.com</a> or call Anthem Member Services 1-844-273-4614.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or by calling Express Scripts Member Services at 1-800-595-0817	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription for up to a 30-day supply \$15 <a href="#">copay</a> /prescription for up to a 90-day supply (retail & mail order)	You are required to pay 100% of the medication cost and then submit for reimbursement. Reimbursement rate calculated based on discounted <a href="#">network</a> cost less applicable <a href="#">copay</a> .	Livongo Diabetes Management: Blood glucose meter, strips & lancets covered 100% (no cost to member). Livongo Member Support 1-800-945-4355 or visit <a href="http://www.welcome.livongo.com/STATEOFME">www.welcome.livongo.com/STATEOFME</a>
	Preferred brand drugs (Tier 2)	\$30 <a href="#">copay</a> /prescription for up to a 30-day supply \$45 <a href="#">copay</a> /prescription for up to a 90-day supply (retail & mail order)	You are required to pay 100% of the medication cost and then submit for reimbursement. Reimbursement rate calculated based on discounted <a href="#">network</a> cost less applicable <a href="#">copay</a> .	First two 90-day treatment regimens for certain tobacco cessation prescription drugs and over-the-counter drugs are covered 100% when obtained from a <a href="#">network</a> pharmacy.  Lifestyle medications (impotency/infertility) are covered at \$50 <a href="#">copay</a> for up to a 30-day supply and \$75 <a href="#">copay</a> for up to a 90-day supply.
	Non-preferred brand drugs (Tier 3)	\$45 <a href="#">copay</a> /prescription for up to a 30-day supply \$70 <a href="#">copay</a> /prescription for up to a 90-day supply (retail & mail order)	You are required to pay 100% of the medication cost and then submit for reimbursement. Reimbursement rate calculated based on discounted <a href="#">network</a> cost less applicable <a href="#">copay</a> .	Individual lifetime fertility cap: \$10,000.  Prescription <a href="#">out-of-pocket maximum limits</a> are \$4,600 (individual) and \$9,200 (family).
	<b><a href="#">Specialty drugs</a> must be filled through <a href="#">Accredo Specialty Pharmacy</a> 1-800-803-2523</b>	25% <a href="#">coinsurance</a> (\$150 max) for up to a 30-day supply	n/a	

For more information about limitations and exceptions, see plan or policy document at [www.maine.gov/bhr/oe/](http://www.maine.gov/bhr/oe/).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		25% <a href="#">coinsurance</a> (\$225 max) for up to a 90-day supply		
If you have outpatient surgery	Facility fee	For ambulatory surgery center 5% <a href="#">coinsurance</a> ; all other <a href="#">network providers</a> 10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a> & <a href="#">urgent care</a>	\$300 <a href="#">copay</a> /visit	\$300 <a href="#">copay</a> /visit	If you are <a href="#">hospitalized</a> inpatient status from the emergency room, the emergency room <a href="#">copayment</a> is waived. All Inpatient admissions for emergency services are subject to postadmission review.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Ground, air or water ambulance must be <a href="#">medically necessary</a> .
	Maine-based walk-in center	\$25 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	Brighton First Care in Portland, ME is <u>not</u> considered a walk-in center; the <a href="#">copay</a> for this facility would be \$300.
	<a href="#">LiveHealth Online</a>	No charge	n/a	Includes board certified doctors and licensed therapists.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-admission review required. If you do not receive preadmission review before you are admitted for non-emergency services, benefits will be reduced by up to \$500 for the admission.  Facility fees will be waived for certain procedures (e.g. bariatric, cardiac, joint replacement, spine) coordinated through the Carrum Health surgery benefit. Call 1-888-855-7806 for more information.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Physician/surgeon fees will be waived for certain procedures (e.g. bariatric, cardiac, joint replacement, spine) coordinated

For more information about limitations and exceptions, see plan or policy document at [www.maine.gov/bhr/oe/](http://www.maine.gov/bhr/oe/).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				through the Carrum Health surgery benefit. Call 1-888-855-7806 for more information.
	Travel expenses	Travel expenses are covered for procedures coordinated through the Carrum Health surgery benefit; all other providers not covered	Not covered	Contact Carrum Health at 1-888-855-7806 or visit <a href="http://my.carrumhealth.com/StateOfMaine">my.carrumhealth.com/StateOfMaine</a> for more information.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">copay</a> /office visit and 10% <a href="#">coinsurance</a> for other outpatient services	40% <a href="#">coinsurance</a>	None
	Inpatient services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
<b>If you are pregnant</b>	Office visits	\$20 <a href="#">PCP copay</a> \$40 <a href="#">specialist copay</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound).  All Inpatient admissions for maternity services are subject to postadmission review.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	Cardiac rehabilitation limited to 36 visits per episode.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 150 days per calendar year.

For more information about limitations and exceptions, see plan or policy document at [www.maine.gov/bhr/oe/](http://www.maine.gov/bhr/oe/).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Automatic Blood Pressure Monitor with Cuff (medical billing code A4670) covered 100% with a prescription from <a href="#">provider</a> and filled with a <a href="#">network durable medical equipment provider</a> .  Prosthetics for limb replacement 10% <a href="#">coinsurance</a> (no deductible); 20% <a href="#">coinsurance</a> (no deductible) <a href="#">out-of-network</a> .
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If your child needs dental or eye care	Children's eye exam	No charge	40% <a href="#">coinsurance</a>	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	None

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Glasses for a child</li> </ul>	<ul style="list-style-type: none"> <li>• Dental Care</li> <li>• Long Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care unless you have been diagnosed with diabetes</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov) or Consumers for Affordable Health Care, Maine Health Insurance Consumer Assistance Program, 1-800-965-7476, [www.maine cahc.org](http://www.maine cahc.org). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

For more information about limitations and exceptions, see plan or policy document at [www.maine.gov/bhr/oe/](http://www.maine.gov/bhr/oe/).

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Anthem Blue Cross & Blue Shield at 1-844-273-4614 or the [Maine Bureau of Insurance](#) at 1-800-300-5000.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

**TTY/TDD: Dial 711**

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (844) 273-4614。

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 273-4614.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 273-4614.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 273-4614

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(844) 273-4614 にお電話ください。

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 273-4614 로 문의하십시오.

**Navajo (Diné):** Dít naaltsoos biká'ígíí lahgo bina'idiłkidgo ná bohónéedzà dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'ı́ hadeesdzih nínizingo koǰı́ hodiılnih (844) 273-4614.

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (844) 273-4614.

**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totoqi. Ina ia talanoa i se tagata faaliliu, vili (844) 273-4614.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 273-4614.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 273-4614.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist</a> copayment	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$1,940</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist</a> copayment	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$6,000
<b>The total Joe would pay is</b>	<b>\$6,810</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist</a> copayment	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,890</b>